RANGE OF REACTIONS AND APPROPRIATE INTERVENTIONS AND SERVICES

Common Reactions to Trauma

Most people experience typical reactions to terrorism and traumatic events. It is critical to reassure survivors that their reactions are normal, regardless of how they may feel. The following chart organizes, by age, typical cognitive, behavioral, physical, and emotional reactions to traumatic events.

All Ages

- ❑ Anger
- ❑ Anxiety
- ❑ Appetite changes
- ❑ Colds or flu-like symptoms
- ❑ Concentration problems
- ❑ Fear of crowds or strangers
- ❑ Fear of darkness
- ❑ Feelings of hopelessness
- ❑ Guilt
- ❑ Headaches
- ❑ Mood-swings
- ❑ Nausea/stomach problems
- ❑ Nightmares
- ❑ Poor work performance
- ❑ Confusion
- ❑ Crying easily
- ❑ Denial
- ❑ Fatigue
- ❑ Fear of being left alone
- ❑ Hyperactivity
- ❑ Hyperviligence/increased watchfulness
- ❑ Increased drug and alcohol use
- ❑ Irritability
- ❑ Isolation
- ❑ Reluctance to leave home or loved ones
- ❑ Sadness
- ❑ Sensitivity to loud noises
- ❑ Sleep difficulties

Children of All Ages

- ❑ Anxiety and irritability
- ❑ Clinging, fear of strangers
- ❑ Fear of separation, being alone
- ❑ Head, stomach, or other aches
- ❑ Increased shyness or aggressiveness
- ❑ Nervousness about the future
- ❑ Regression to immature behavior
- ❑ Reluctance to go to school
- ❑ Sadness and crying
- ❑ Withdrawal
- ❑ Worry, nightmares

Preschool Age (1–5)

- ❑ Changes in eating habits
- ❑ Changes in sleeping habits
- ❑ Clinging to parent
- ❑ Disobedience
- ❑ Fear of animals, the dark, "monsters"
- ❑ Hyperactivity
- ❑ Speech difficulties
- ❑ Regression to earlier behavior (thumbsucking, bedwetting)

Early Childhood (5–11)

- ❑ Increased aggressiveness
- ❑ Changes in eating/sleeping habits
- ❑ Difficulty concentrating
- ❑ Regression to earlier behavior
- ❑ Competing more for the attention of parents
- ❑ Fear of going to school, the dark, "monsters"
- ❑ Drop in school performance
- ❑ Desire to sleep with parents

Adolescence (12–14)

- ❑ Abandonment of chores, schoolwork, and other responsibilities previously handled
- ❑ Disruptiveness at home or in the classroom
- ❑ Experimentation with high-risk behaviors such as drinking or drug abuse
- ❑ Vigorous competition for attention from parents and teachers
- ❑ Resisting authority

Problematic Reactions

The following may indicate the need for more extensive intervention and counseling:

- ❑ Disorientation—dazed; memory loss; inability to give date or time, state where he or she is, recall events of the past 24 hours, or understand what is happening
- ❑ Inability to care for self—not eating, bathing, or changing clothes; inability to manage activities of daily living
- ❑ Suicidal or homicidal thoughts or plans
- ❑ Problematic use of alcohol or drugs
- ❑ Domestic violence, child abuse, or elder abuse
- ❑ Any common reaction may require intervention if it interferes with daily functioning

Risk Factors for Problematic Reactions to Trauma[2]

The following are risk factors at different stages of a terrorist event that may help identify individuals and groups who are more susceptible to having a more problematic stress response. Additional, immediate outreach and intervention efforts may be needed in these situations.

Personal Risk Factors Before Trauma

- Past history of Posttraumatic Stress Disorder (PSTD)
- History of childhood abuse
- Early attachment issues
- Family history of trauma
- Psychological difficulties
- History of substance abuse
- Female gender
- Younger age
- Low socioeconomic status
- Lower intelligence

[2] Adapted from presentations made by Dr. Rony Berger, Psy.D., at Natal Israel Trauma Center for Victims of Terror and War, on June 11 and 12, 2002.

Personal Risk Factors During Trauma and 24 Hours After Trauma

- Degree and intensity of exposure
- Dissociation
- Intrusion and avoidance
- Depression
- Hyperarousal
- Negative self-talk
- Lack of immediate social support

Personal Risk Factors After Trauma

- Lack of societal acknowledgment
- Lack of ongoing social support
- Stressful life events
- Unproductive family patterns

Dynamics of Symptoms Over Time

Post-event traumatic reactions may be:

- Intense or mild
- Immediate or delayed
- Cumulative in intensity
- Reactivated by:
  - Subsequent traumatic experiences
  - Reminders of the event:
    - Anniversaries
    - Area or object associated with the event (e.g., planes, building)

Symptoms may also be activated by vicarious trauma, such as media exposure or contact with people involved in the terrorist event.

Intervention Goals[3]

At the scene of a terrorist event, facilitating physical and emotional safety is the primary objective. A common response of many survivors is to feel highly vulnerable and fearful; therefore, interventions emphasize protection and safety as well as promote a sense of security. The four initial intervention goals are:

- Identify those in need of immediate medical attention
- Provide supportive assistance and protection from harm
- Facilitate connecting survivors with family and friends
- Provide information about the status of the crime scene, perpetrator(s), and immediate law enforcement efforts

Once safety is established, the following four intervention goals should be targeted:

- Alleviate distress through supportive listening, providing comfort, and empathy
- Facilitate effective problem-solving of immediate concerns
- Recognize and address pre-existing psychiatric or other health conditions in the context of the demands of the current stressor
- Provide psychoeducational information regarding post-trauma reactions and coping strategies

Overview of Interventions and Services

Immediately following a terrorist event, the primary objective of mental health interventions are to facilitate emotional stabilization. After the survivor has achieved some degree of emotional stabilization and has the ability to verbalize and process limited information, interventions should aim to alleviate distress and help with problem-solving and recovery. The following is a description of the services conducted by mental health professionals. The role of the paraprofessional is described on page 31.

Psychological First Aid[4]

Rapid assessment is conducted at the scene by mental health professionals to identify survivors who are most psychologically distressed and in need of medical attention. Initially, triage decisions are based on observable and apparent data. Persons experiencing physiological reactions such as shaking, screaming, or disorientation, may need to receive emergency medical attention. Emergency intervention involves three basic concepts: protect, direct, and connect.

[3] DeWolfe, D.J. (Ed.). (In press). Mental health response to mass violence and terrorism: A training manual. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.
[4] Ibid.

- Survivors need to be **protected** from viewing traumatic stimuli from the event. In addition, they need to be protected from curious onlookers and the media.
- When disoriented or in shock, survivors need to be **directed** away from the trauma scene and danger, and into a safe and protected environment. A brief human connection with a disaster mental health worker can help to orient and calm them.
- Disaster mental health workers assist survivors by **connecting** them with loved ones, as well as with needed information and resources.

Psychological support involves comforting the survivor, addressing immediate physical necessities, listening to and validating feelings and stories, and other immediate needs.

Crisis Intervention[5]

While crisis intervention is somewhat similar to psychological first aid, it goes beyond the first stages of the disaster to:

- Assist survivors to regain some sense of control and mastery over their immediate situations
- Reestablish rational problem-solving abilities

An underlying assumption is that the survivor's distress and coping difficulties are due to the suddenness, horror, and catastrophic nature of the event. Crisis intervention typically involves five components:

- Promoting safety and security (e.g., finding the survivor a comfortable place to sit, giving the survivor something to drink)
- Exploring the person's experience with the disaster (e.g., offering to talk about what happened, providing reassurance if the person is too traumatized to talk)
- Identifying current priority needs, problems, and possible solutions
- Assessing functioning and coping skills (e.g., asking how he or she is doing, making referrals if needed)
- Providing reassurance, normalization, psychoeducation, and practical assistance

Informational Briefings[6]

Survivors will seek information about the location and well-being of their loved ones, levels of threat and danger, procedural information, criminal investigation updates, etc. Disaster mental health workers do not provide informational briefings, but they may consult officials about the need to do so and offer to be present during briefings to provide support as needed. Generally,

[5] Ibid.
[6] Ibid.

senior managers on the disaster mental health staff are designated to work with officials. They may offer suggestions to officials about:

- Appropriate language/terminology
- Level of detail for sensitive information
- Approaches for addressing intense emotional reactions
- Language to use in conveying messages of compassion and condolence

Psychological Debriefing[7]

Psychological debriefing is a group intervention that has been used with a wide range of groups, including emergency responders, survivors, and community groups. It involves a series of stages that move participants from a cognitive view of the event, to discussion and expression of emotions and reactions, and then back to more cognitively focused learning about coping and problem solving. Debriefings can be set up for specific groups according to need. Components of psychological debriefing consist of:

- The facilitator introducing the process and ground rules
- The participants describing the stories of their involvement with the event
- The participants describing their thoughts, feelings, and reactions during and since the event
- The facilitator validating and normalizing reactions and providing psychoeducation
- The facilitator wrapping up the session by addressing issues, distributing brochures on stress and coping, and discussing when and how to seek professional help

Brief Counseling Interventions[8]

The therapeutic goals of brief counseling interventions involve the following:

- Stabilizing emotions and regulating distress
- Confronting and working with the realities associated with the event
- Expressing emotions during and since the event, including anger, anxiety, and fear
- Understanding and managing post-trauma symptoms and grief reactions
- Developing a sense of meaning regarding the trauma
- Coming to accept that the event and resulting losses are part of one's life story

[7] Ibid.
[8] Ibid.

Support and Therapy Groups[9]

Support and therapy groups are especially appropriate for survivors of terrorist events because of the opportunity for social support through the validation and normalization of thoughts, emotions, and post-trauma symptoms. Telling one's "trauma story" in the supportive presence of others can be powerfully helpful. In addition, group reinforcement for using stress management and problem-solving techniques may promote courage and creativity. Sharing information about service and financial resources, as well as other types of assistance, is another important function of support groups. Grief counseling is an important component of group services. It is recommended that groups be facilitated by an experienced mental health professional, ideally with a co-facilitator, and be time-limited with expectations defined at the outset.

Mental Health Consultation[10]

Mental health professionals may be brought into decision-making and planning teams to advise leaders regarding mental health issues, such as mental health support and leave time for rescue and recovery workers, as well as rituals and memorials to honor the dead.

Support Role During Death Notification[11]

Mental health professionals typically do not deliver information regarding deaths but may participate on teams who accompany the person responsible for this notification. Mental health professionals provide support to the family receiving the news and, at times, to those conducting the notifications. They can also provide information to those responsible for the notification on specific cultural or ethnic customs regarding the expression of grief and rituals surrounding death and burial.

Death Notification Procedure

Mothers Against Drunk Driving (MADD) developed a curriculum on compassionate death notification for professional counselors and victim advocates. The curriculum is summarized below:

1. The coroner or medical examiner is absolutely responsible for determining the identity of the deceased.
2. Notify in person. Do not call. Do not take any possessions of the victim to the notification. If there is absolutely no alternative to a phone call, arrange for a professional, neighbor, or a friend to be with the next of kin when the call comes.
3. Take someone with you (for example, an official who was at the scene, clergy, and someone who is experienced in dealing with shock and/or trained in CPR/medical emergency). Next of kin have been known to suffer heart attacks when notified. If a large group is to be notified, have a large team of notifiers.
4. Talk about your reactions to the death with your team member(s) before the notification to enable you to better focus on the family when you arrive.
5. Present credentials and ask to come in.
6. Sit down, ask them to sit down, and be sure you have the nearest next of kin (do not notify siblings before notifying parents or spouse). Never notify a child. Never use a child as a translator.
7. Use the victim's name... "Are you the parents of _____?"

[9] Ibid.
[10] Ibid.
[11] Ibid.

8. Inform simply and directly with warmth and compassion.
9. Do not use expressions like "expired," "passed away," or "we've lost _____."
10. Sample script: "I'm afraid I have some very bad news for you." Pause a moment to allow them to "prepare." "[Name] has been involved in _____ and (s)he has died." Pause again. "I am so sorry." Adding your condolence is very important, because it expresses feelings rather than facts and invites them to express their own.
11. Continue to use the words "dead" or "died" through ongoing conversation. Continue to use the victim's name, not "body" or "the deceased."
12. Do not blame the victim in any way for what happened, even though he/she may have been fully or partially at fault.
13. Do not discount feelings, theirs or yours. Intense reactions are normal. Expect fight, flight, freezing, or other forms of regression. If someone goes into shock, have them lie down, elevate their feet, keep them warm, monitor breathing and pulse, and call for medical assistance.
14. Join the survivors in their grief without being overwhelmed by it. Do not use clichés. Helpful remarks are simple, direct, validate, normalize, assure, empower, and express concern. *Examples:* "I am so sorry." "It's harder than people think." "Most people who have gone through this react similarly to what you are experiencing." "If I were in your situation, I'd feel very _____ too."
15. Answer all questions honestly (requires knowing the facts before you go). Do not give more detail than is asked for, but be honest in your answers.
16. Offer to make calls, arrange for child care, call clergy, relatives, employer. Provide them with a list of the calls you make, as they will have difficulty remembering what you have told them.
17. When a child is killed and one parent is at home, notify that parent, then offer to take them to notify the other parent.
18. Do not speak to the media without the family's permission.
19. If identification of the body is necessary, transport next of kin to and from the morgue, and help prepare them by giving a physical description of the morgue and telling them that [Name] will look pale because blood settles to the gravitational lowest point.
20. Do not leave survivors alone. Arrange for someone to come, and wait until they arrive before leaving.
21. When leaving, let the persons know you will check back the next day to see how they are doing and if there is anything else you can do for them.
22. Call and visit again the next day. If the family does not want you to come, spend some time on the phone and re-express willingness to answer all questions. They will probably have more questions than when they were first notified.
23. Ask the family if they are ready to receive [Name's] clothing, jewelry, etc. Honor their wishes. Possessions should be presented neatly in a box and not in a trash bag. Clothing should be dried thoroughly to eliminate bad odor. When the family receives the items, explain what the box contains and the condition of the items so they will know what to expect when they decide to open it.
24. If there is anything positive to say about the last moments, share them now. Give assurances, such as "most people who are severely injured do not remember the direct assault and do not feel pain for some time." Do not say, "s(he) did not know what hit them" unless you are absolutely sure.
25. Let the survivor(s) know you care. The most beloved professionals and other first responders are those who are willing to share the pain of the loss. Attend the funeral if possible. This will mean a great deal to the family and reinforces a positive image of your profession.
26. Know exactly how to access immediate medical or mental health care should family members experience a crisis reaction that is beyond your response capability.
27. Debrief your own personal reactions with caring and qualified disaster mental health personnel on a frequent and regular basis. Do not try to carry the emotional pain all by yourself, and do not let your emotions and the stress you naturally experience in empathizing with the bereaved build into a problem for you.

Community Outreach[12]

Community outreach is an essential component of a comprehensive mental health response to acts of mass violence and terrorism. Within hours of the event, survivors and their families may be geographically dispersed. Disaster mental health workers need to consider the nature of the event and its impact, and develop a flexible plan for community outreach. Community outreach involves:

- Initiating supportive and helpful contact at sites where survivors and family members are gathered
- Reaching out to survivors through the media, the Internet, and maintaining 24-hour telephone hotlines with responders who speak different languages
- Participating in or conducting meetings for preexisting groups through faith communities, schools, employers, community centers, and other organizations
- Providing psychoeducational, resource, and referral information to health care and human service providers, police and fire personnel, and other local community workers

[12] Ibid.